

BARRIERS AND FACILITATORS OF BREASTFEEDING FOR PRIMIPAROUS

ACTIVE DUTY MILITARY MOTHERS: A QUALITATIVE STUDY

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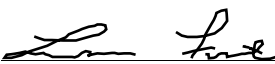
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ABSTRACT

Active duty military mothers have obligations to the military and their families that do not always balance. Little has been reported about the incidence and duration of breastfeeding in the active duty population. One study cited a breastfeeding initiation rate just under 80 % for active duty women, but most stopped breastfeeding between three to eight weeks postpartum. This descriptive study describes the barriers and facilitators of breastfeeding for primiparous active duty military mothers, from their perspective, using a Husserlian phenomenological approach. A semi-structured interview guide was reviewed by experienced qualitative researchers, and used to guide the interviews. A pilot interview was conducted. Purposive sampling was used to recruit four study participants -active duty military primiparous women- at the Pediatric Clinic of a large medical center on the East coast. After bracketing pre-existing assumptions and knowledge, interviewing began. The participants were encouraged to divulge the factors that influenced their decision to feed their infant. Analysis of the data began as it was collected. The transcripts of the interviews was reviewed several times to uncover themes or essences and essential relationships. Learning the motivators that influence active duty military women to breastfeed or not to breastfeed may lead to interventions that may potentially increase the initiation and duration of breastfeeding in primiparous active duty military mothers. The overall theme was support. Other themes were going back to work, and continuation or discontinuation of breastfeeding.

Key Words: **breastfeeding** **military nursing** **working mother** **barriers** **facilitators**
qualitative milk, human lactation feeding practices

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By

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PREFACE

This research was conducted to provide information on the factors that influence primiparous active duty military mothers in their decision to breastfeed or to feed their infant formula. It is designed to provide information about the things active duty military women consider influential in deciding how to feed their infant in order to possibly improve support for this population.

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To my husband John and daughter Catherine, I dedicate the creation of this thesis.

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CHAPTER ONE - INTRODUCTION

Background

There are more mothers in the work force and serving on active duty in the military than there have ever been in the past (Corbett-Dick & Bezek, 1997). Despite the increase in active duty mothers, the number who breastfeed remains low. At one Army hospital, less than half the active duty military mothers initiated breastfeeding soon after delivery, and most weaned their infants before two months postpartum (Kugler, Lee, & Lewis, 1994; Madlon-Kay & Carr, 1988).

Kugler, Lee, and Lewis (1994) studied a cohort of 356 mothers who delivered infants at four United States military medical facilities between January 1993 and February 1994 using an initial questionnaire and a follow up questionnaire six months postpartum. They found that breastfeeding rates dropped off dramatically by three months postpartum for active duty and family member women in a military community.

Although little is known about the incidence and extent of breastfeeding in the active duty population, civilian working women have greater intention of breastfeeding than women not in the work force, but tend to breastfeed their infants for shorter time periods, especially after returning to work (Martinez & Krieger, 1985). Laughlin, Clapp-Channing, Gehlbach, Pollard, and McCutchen (1985) however, found that duration of breastfeeding was not affected by how soon the mother expected to return to work. In a study of active duty women, the initiation and duration of breastfeeding were not affected by shortened maternity leave (Madlon-Kay & Carr, 1988).

The health-care community and organizations such as the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) (1989) promote

breastfeeding as the preferred means to feed infants. The goal of the United States Surgeon General, as outlined in Healthy People 2000 (Public Health Service [PHS], 1991), is to increase initiation of breastfeeding to 75 % or more and the incidence of breastfeeding at six months postpartum to 50 % or greater. Current rates fall well below that goal.

The American Academy of Pediatrics (AAP) recommends breastfeeding “for at least 12 months, and thereafter as long as mutually desired” (AAP Work Group on Breastfeeding [AAP Work Group], 1997, p. 1037). The developmental, economic, immunologic, psychological, social, health, nutritional, and environmental benefits of breastfeeding to infant and mother have been documented in a variety of sources, and are listed in the recent policy statement by the AAP. “Epidemiologic research shows that human milk and breastfeeding of infants provide advantages with regard to general health, growth, and development, while significantly decreasing risk for a large number of acute and chronic diseases (p. 1035).

Among mainly middle-class subjects in the United States, Canada, Europe and other developed countries, research shows that human milk and breastfeeding reduce the incidence of diarrhea, lower respiratory infection, otitis media, bacteremia, bacterial meningitis, botulism, urinary tract infection, and necrotizing enterocolitis (AAP Work Group, 1997). Human milk may possibly have a protective effect against sudden infant death syndrome, Type 1 diabetes mellitus, Crohn’s disease, ulcerative colitis, lymphoma, allergic diseases, and other chronic digestive diseases. Breastfeeding has also been linked to improving cognitive development (Morrow-Tlucak, Haude, & Ernhart, 1988; Wang & Wu, 1996). In addition, breastmilk provides the optimum balance of nutrients,

enzymes, immunoglobulin, anti-infective and anti-inflammatory substances, hormones, and growth factors (PHS, 1991). The ratio of these components of breastmilk changes to match the needs of the developing infant. For example, the amount of immunoglobulin decreases about the time that a baby's own immune system starts to function well.

Breastfeeding also allows the mother and infant to spend regular, intense periods of time together. These times are precious and rare for working mothers. A harried mother can feel that she is making time for developing a solid relationship with her infant, as well as providing many benefits for the infant and herself by breastfeeding.

Many health benefits are also possible to mothers who breastfeed. Breastfeeding increases oxytocin levels, allowing more rapid involution of the uterus and decreased postpartum bleeding. Amenorrhea caused by breastfeeding results in less menstrual blood loss in the months after delivery (AAP Work Group, 1997). Lactation facilitates a quicker return to the mother's prepregnant state (PHS, 1991). Breastfeeding women have earlier return to their prepregnant weight, suppression of ovulation with increased child-spacing, improved bone remineralization after delivery, less incidence of hip fracture postmenopausally, and decreased risk of ovarian cancer and premenopausal breast cancer (AAP Work Group, 1997). In addition to physiologic benefits, there are social, economic, and readiness benefits to breastfeeding.

The savings attributed to breastfeeding greatly outweigh the cost. Infant formula costs approximately \$900 per child during the first year. By breastfeeding, a family could save more than \$400 per child in the first year, despite the increased amount of fluid and caloric intake required by lactating women (AAP Work Group, 1997). When one includes the savings in health care costs and missed work days, the savings quickly

build. Kaiser Permanente Health Maintenance Organization (1995) found that non-breastfed infants required \$1,435.00 more in office visits, prescription drugs, and hospitalizations per infant in the first year of life than breastfed infants. Reduced rate of infant illness and the quicker return of mothers to their prepregnant state allows parents to provide more attention to siblings and other family duties, and reduces work absenteeism and lost income. Tangible benefits to employers include less work days missed due to child illness and exclusion from child care, and decreased costs for health care provided (Corbett-Dick & Bezek, 1997).

Some women may be concerned that their breastmilk may cause harm to their infant if they continue to come in contact with hazards in the workplace. Breastfeeding may be chosen by active duty mothers as the method by which they feed their infants with few contraindications, such as occupational exposures to radiation and hazardous materials (Croft, 1995). Benefits of breastfeeding greatly outweigh the disadvantages and should be promoted for active duty mothers as much as they are for the general population. All the previously mentioned benefits of breastfeeding apply to the active duty military family. The potential benefits may be even more important for active duty military families than the general population because of the need to conserve the fighting strength. Active duty military members need to be returned to duty as soon as possible, in the best physical condition possible, in order to complete the mission. There are many benefits of breastfeeding for active duty military families, even when the mother is not the active duty member. Active duty military members whose infants have been breastfed may miss less duty days due to maternal or infant illness, have less cause for concern regarding the health of the infant and mother (secondary to protective

immunologic effects to the infant), and less guilt and stress regarding potential conflicts between military and familial duties.

All military members must meet height and weight standards specific to their branch of service. The active duty military mother is given a certain time period within which she must return to a specified weight for her height and pass a physical fitness test or face unfavorable actions, such as missing opportunities for promotion, additional training, and so forth. Breastfeeding women return to their prepregnant weight faster secondary to increased calories required to support the metabolic demands of the mother and the infant (Corbett-Dick & Bezek, 1997; Lawrence, 1994).

Active duty military women who breastfeed may return to duty in better physiologic condition, hence improving readiness and morale of individuals and units. Active duty mothers have more duty responsibilities and more demands placed on them than do many civilian women (Wahl & Randall, 1996). Family and military obligations often tug military mothers in opposite directions, creating conflict. Many active duty women feel stress about going back to work and not being able to breastfeed their infant on demand. While Corbett-Dick and Bezek (1997) found that women who breastfed their infants had a feeling of providing the best possible care for their infants when they continued to breastfeed, and expressed milk to feed the infant while away, active duty women who breastfeed their infants may be forced to wean them early once back in a field environment or on deployment (Wahl & Randall, 1996). Depending on the unit, continuing breastfeeding may be difficult, at best, or impossible.

Aim of the Study

The purpose of this qualitative descriptive study was to describe the barriers and facilitators of breastfeeding for primiparous active duty military mothers, from the mother's perspective. For simplicity, this study looked at only primiparous women, because parity has been shown to affect breastfeeding initiation and duration. Kieffer, Novotny, Welch, Mar, and Thiele (1997) found that multiparous women tend to feed their new infant the way they fed other children.

Qualitative research methods use a holistic view (Burns & Grove, 1997). This approach to research was initially developed by sociologic, psychologic, and anthropologic researchers and has been embraced by nurse researchers who have continued to refine qualitative methods (Boyd, 1993). Qualitative descriptive methods provide rich detail and should precede all other modes, discovery, emergent fit, and intervention. Descriptive research is appropriate for entry-level investigators. Phenomenology, as a research method, has traditionally been a method of describing experiences from the perspective of the person living the experience, rather than from observation by the researcher. It is a "process of struggling to see" (p. 90).

Phenomenology is also a philosophical movement. In order to comprehend the research method and interpret the data and conclusions, it is essential to understand the themes that constitute the philosophy. Reality and truth (interpretation of phenomena) are subjective and based on a person's interaction with the surrounding world. Each person has unique experiences, hence, unique reality. Phenomenologists search for the meaning of lived experience. Phenomenology seeks to identify and describe these experiences without prejudices, preconceptions, or causal explanations. The researcher

brackets or sets aside previous knowledge relating to the phenomenon (phenomenological reduction) being studied so that it can be seen in its purest form. Scientific rigor is inherent in this method, and is made clear when the informants recognize the descriptions (Ray, 1994, p. 138).

During the interview process phenomena are revealed that are recognizable to each of us and are credible for that reason. The phenomena that are being studied are often overlooked as common experiences. The meaning of these phenomena cannot truly be “known” without bracketing prior knowledge and experiences. This method can accurately portray experiences from the perspective of the informant so that new meaning can be revealed and experiences can be described that may shape future interventions and research.

There is little reported research about the barriers and facilitators of breastfeeding for this specific population, although barriers and facilitators of breastfeeding for mothers in the general civilian work force and for mothers in general have been documented (Auerbach & Guss, 1984; Ryan, 1997). Few examples of research using qualitative methods have been found regarding breastfeeding among active duty military women. Personal interviews were used to explore the experiences of primiparous active duty military mothers with regard to barriers and facilitators of breastfeeding. The sample was obtained from active duty primiparous mothers who have children aged six to eighteen months and who responded to flyers posted in and near a clinic at a large, local military hospital clinic where well baby and same day appointments are conducted.

To assist in alleviating coercion, participants were recruited via posted flyers regarding the study. The flyers explained the purposes of the study, requested voluntary

participation, listed the inclusionary criteria, and length of time involved. A copy of the recruitment flyer is included as Appendix A. Flyers were posted in the Pediatric Clinic. Two volunteers were acquaintances of the researcher who met the criteria for inclusion in the study. All volunteers use the Pediatric Clinic for the primary care of their respective infant. Consent was obtained from the volunteers who responded to the flyers (Appendix B). No volunteers wished to withdraw from the interview. Specific methodologic issues are discussed in Chapters 3 and 4.

Potential contributions of this study included a description of barriers and facilitators to breastfeeding as experienced by primiparous active duty military mothers. Understanding the motivators that influenced their decision to breastfeed or not to breastfeed their infants could lead to interventions that may potentially increase the initiation and duration of breastfeeding in primiparous active duty military mothers.

Breastfeeding initiation and duration are known to be increased when health care providers encourage breastfeeding and provide education about breastfeeding (Kistin, Benton, Rao, & Sullivan, 1990). Mothers regard health care professionals as important, reliable resources for information about breastfeeding, and other infant issues (Bagwell, Kendrick, Stitt, & Leeper, 1993). Health care providers are in a prime position, in the prenatal and postpartum periods, to influence the decision to initiate and continue to breastfeed. Frequently, active duty families are stationed in locations far from their extended families and support systems, which new mothers traditionally look to for advice and support for breastfeeding. In the absence of such support, advanced practice nurses are able to provide the encouragement and knowledge that new mothers need. “The role of the pediatric health care provider must include advocacy for mothers to

choose breastfeeding and provision of information and support to women as they manage the dual responsibilities of home and employment” (Corbett-Dick & Bezek, 1997, p. 14).

The health care provider can ease the mother’s return to duty with anticipatory guidance about work schedule, feeding patterns, expressing milk, and time management hints.

Family Nurse Practitioners provide care for entire families- infants, mothers, fathers - and are ideal breastfeeding educators and supporters,

The functions of advanced practice nurses as illness-preventing, health-promoting, health care providers meshes well with the goals of the Putting Prevention Into Practice (PPIP) program initiated by the Department of Health and Human Services and the Surgeon General’s Healthy People 2000 (PHS, 1991) initiatives. “The advanced practice registered nurse employs complex strategies, interventions, and teaching to promote, maintain, and improve health, and prevent illness and injury” (American Nurses Association [ANA], 1996, p. 13).

Breastfeeding has benefits that may positively affect health, economic, and readiness issues. Breastfeeding can lead to healthy families and a healthy military force secondary to the benefits to the overall health of families, in particular mothers and babies.

Research Question

The research question examined was: What are the barriers and facilitators to breastfeeding for primiparous active duty mothers?

Definition of Relevant Terms

As recommended for qualitative inquiry, for the purpose of this study only the following operational definitions were used:

Health care provider. A nurse practitioner, midwife, physician's assistant, family practice physician, obstetrician, or pediatrician.

Advanced practice nurse. A registered nurse with the additional formal education, clinical experience, and certification required by law to practice.

Barriers. Factors that a mother felt kept her from breastfeeding at all, requiring she exclusively feed her infant with another nutritional source; or kept her from breastfeeding for at least six months without resorting to supplementation with another nutritional source.

Facilitators. Factors that a mother felt supported her to breastfeed for at least six months, with infrequent supplementation of another nutritional source.

Primiparous. A woman who has delivered one live infant.

Active duty military. A man or woman whose full time occupation is as a serving member of a United States military service, Air Force, Army, Marine Corps, or Navy.

Successful breastfeeding. Breastfeeding for six months or longer, with no more than occasional supplementation (less than two bottles of formula daily, breastmilk all other times).

CHAPTER TWO - EVOLUTION OF THE STUDY

Introduction

A review of literature revealed that many professional bodies strongly advocate breastfeeding since it is seen as a major method for health promotion and illness prevention. Human breast milk has been widely endorsed as the best food for infants. The World Health Organization (WHO) and United Nation's Children's Fund (UNICEF) (1989) are geared toward promoting health and preventing disease among all children and adults, in the world, and recommend that infants be breastfed for two or more years. The American Academy of Pediatrics (AAP) recommends that mothers exclusively breastfeed their infants for the first four to six months of life, and continue to breastfeed for the first year (together with baby foods) and even longer as mother and child wish (American Academy of Pediatrics Work Group on Breastfeeding [AAP Work Group], 1997). The American Dietetic Association (ADA, 1993) recommends exclusive breastfeeding until the infant is five to six months of age, "followed by the introduction of age-appropriate solid foods and juices while breastfeeding continues for the first year of life or beyond" (p. 467).

The United States Surgeon General acknowledges the role breastfeeding has in promoting health of infants and their mothers. In the Healthy People 2000 (PHS, 1991), National Health Promotion and Disease Prevention Objectives, the Surgeon General set the goal for initiating breastfeeding in the early postpartum period at 75%, and to increase to 50% the duration of breastfeeding until the infant is at least five to six months of age. According to the Ross Laboratories Mothers' Survey, only 59.2% of women in the United States initiated breastfeeding, and only 21.7% were breastfeeding at six months

postpartum in 1996 (Ryan, 1997). This disparity caused the researcher to focus on the barriers and facilitators to breastfeeding as a thesis topic.

Barriers and Facilitators of Breastfeeding

Studies have shown that in the first few postpartum weeks women are likely to stop breastfeeding because of sore and cracked nipples, sucking difficulties, and difficulty helping the infant latch onto the breast correctly. Women who terminate breastfeeding prior to six months generally intend only to breastfeed for less than six months and lack confidence in their ability to breastfeed. This indicates that breastfeeding intention is a predictor of the length of time a woman breastfeeds her infant (Janke, 1993; Lawson & Tulloch, 1995).

Mothers tend to feed subsequent infants the same way they fed their first child (Janke, 1993). In the United States women have identified as barriers to breastfeeding the fear of not producing enough milk or milk that is inadequate for the infant, guilt, shame, modesty, embarrassment, distaste, and other anxieties. This is more frequent in lower socioeconomic groups (Lawrence, 1994). Returning to school or work is a frequent barrier to breastfeeding. Lack of flexibility in schedules, short maternity leave, and lack of appropriate facilities to pump and store breastmilk have also been reported (Auerbach & Guss, 1984).

Reduced incidence and duration of breastfeeding are associated with lower educational levels, lower socioeconomic status, and younger age (Janke, 1988, Lawson & Tulloch, 1995; Ryan, 1997). Awareness of breastfeeding benefits, infant nutrition, and realistic expectations of a baby's needs are predictors of breastfeeding duration. Emotional support from partner, friends, family, and medical providers combined with

knowledge of breastfeeding benefits impacts breastfeeding incidence and duration (Kaplowitz & Olsen, 1983; Janke, 1988). Breastfeeding education has been shown to positively affect the incidence and duration of breastfeeding (Lawson & Tulloch, 1995; Kaplowitz & Olsen, 1983; Saunders & Carroll, 1988).

Breastfeeding and Maternal Employment

The researcher was particularly interested in research relating to mothers returning to work or school. Surgeon General C. Everett Koop stated that “health care providers and society in general must identify and reduce the barriers which keep women from beginning or continuing to breastfeed their infants” (Corbett, Dick, & Bezek, 1997, p. 13). Paid employment has been noted as a barrier to breastfeeding. Infant weaning before twelve months of age is most likely when the mother returns to work full-time before sixteen weeks postpartum (Auerbach & Guss, 1984). Part-time workers breastfeed their infants for more than one year more often than do full-time workers. Women who return to work soon after childbirth have to work hard to continue breastfeeding, but tend to value the experience and think well of themselves as mothers (Corbett-Dick & Bezek, 1997).

In an unpublished study by Kugler, Lee, and Lewis (1994) of 356 active duty military and family member mothers in four U.S. military medical facilities, 80% chose to initiate breastfeeding. The participants completed an initial survey on the day after delivery of their infant and another survey at six months postpartum. By six months postpartum the rate was 36%, and 86% of those who stopped early would have preferred to have breastfed longer. Reasons for choosing formula included the need or decision to return to work, concern that the baby was not getting enough milk, and the increased

availability of formula over breastmilk. However, in a study of purely active duty women conducted at a single Army hospital, Madlon-Kay and Carr (1988) found that only 41% initiated breastfeeding and most had weaned their infants between three weeks and two months postpartum. The soldiers returned to work during that time. The researchers sought to note any effect that decreasing maternity leave from 42 days to 30 days had on breastfeeding initiation and duration by reviewing nursery records of infant feeding method for one year before and after the change in the maternity leave policy. Infant outpatient records were reviewed to determine the duration of breastfeeding. Of the 58 soldiers whose records were reviewed 30 soldiers had received 42 days of maternity leave, and 28 soldiers had received 30 days of maternity leave. At two months postpartum 37% of the soldiers who received 42 days of maternity leave were still breastfeeding versus 32% of the soldiers who received 30 days. At six months 10% of the soldiers who received 42 days and 11% of the mothers who received only 30 days were still breastfeeding. At twelve months the rates were 11% and none, respectively. Unfortunately, reasons for stopping breastfeeding were not published.

Relationship to Nursing

Lack of health care professional support has been cited as a barrier to successful breastfeeding (Coreil, Bryant, Westover, & Bailey, 1995). Conversely, a supportive health care provider can increase the duration of breastfeeding (Barron, Lane, Hannan, Struempler, & Williams, 1988). Coreil and colleagues (1995) found a lack of preparation of and support for breastfeeding mothers on the part of health care providers. Women are most influenced by physician opinion but usually look to nurses and dietitians for breastfeeding education (Bagwell et al., 1993). Physicians' training frequently does not

prepare them for supporting breastfeeding, but nurse practitioners that provide care for the mother and infant are ideal for the critical task of providing anticipatory education and support (Coreil et al., 1995; Lawrence, 1982). Health care providers can anticipate a mother returning to work or school and provide information and support so she may continue to breastfeed successfully. General breastfeeding guidance can be provided, but for a mother considering returning to work the provider can present information regarding work scheduling, feeding patterns, expressing milk, storage, organization and time management techniques. Employers and health care providers can play integral roles in promoting the initiation and duration of breastfeeding, and supporting mothers who breastfeed (Corbett-Dick & Bezek, 1997).

This review of literature illustrated that information available regarding breastfeeding is vast although incomplete, particularly data related to active duty military women. The article by Madlon-Kay and Carr (1988) is the only published study directly pertaining to the incidence, duration, and factors that influence the decision to breastfeed among active duty military women. The researcher hopes to identify the factors that influence primiparous active duty military women in their decision whether to breastfeed and to use this information to guide interventions to promote breastfeeding in this population.

CHAPTER THREE - QUALITATIVE METHOD OF INQUIRY

Qualitative research is “a systematic, interactive, subjective approach used to describe life experiences and give them meaning. In contrast, quantitative research is a formal, objective, systematic process to describe, test relationships, and examine cause and effect interactions among variables” (Burns & Grove, 1993, p. 791). The need to explain phenomena that are difficult to measure objectively led to the development of qualitative research. Key features of qualitative research that set it apart from quantitative research are theemic perspective, holistic perspective, and an inductive and interactive inquiry process (Morse, 1992, p. 1). Eliciting meaning, experience or perceptions from the participant’s viewpoint (emic perspective), as opposed to the external or researcher’s viewpoint (etic perspective), is a hallmark of qualitative research methods. An emic perspective requires acknowledgement of the informant’s beliefs and values behind the phenomenon, and avoidance of imposing the researcher’s personal philosophy on the data acquired. Truth and reality vary according to which belief system individuals are committed.

The holistic perception characteristic of qualitative research approaches “the phenomenon of interest by considering the underlying values and the context as part of the phenomena” (Morse, 1992, p. 2). There is an inductive and interactive process of inquiry between the researcher and the data. The researcher develops understanding and insight about the phenomenon of interest during the analytical process. Quantitative studies emphasize measurement and analysis of causal relationships between variables rather than processes, and are value-free by design. Qualitative methods acknowledge

the constraints of daily life of the social world and ground (base) findings in it (Denzin & Lincoln, 1994).

Phenomenological research is an inductive, descriptive qualitative method that stems from the philosophy of phenomenology (Burns & Grove, 1997). Its purpose is to describe an experience as it is lived by that person. Phenomenologists ask the questions “What is the meaning of this person’s lived experience? And how do we know?” Each person has a unique belief system, and thus a unique view of reality and the truth. Therefore, the individual is the only reliable person to answer and to interpret the answer to the question. In order to comprehend the experience, the researcher further interprets the individual’s answer. Reality and truth are interactive with the world around us and are dependent on other persons, objects, events, circumstances, and situations. (Boyd, 1993). Phenomenology searches for the unique experiences of life. “The phenomenological method is one of direct inquiry in which constant questioning provides further insights into the lived experience” (Morse, 1992, p.91). Phenomenology derives power from the sharing of the meaning of experiences. Understanding and insight are permitted through exploration, reflection and expression. The phenomena or things that are revealed by a researcher during exploration are recognizable to each of us and are credible for that reason (Ray, 1994).

Edmund Husserl, the founder of phenomenology, claimed that by bracketing or setting aside one’s prior knowledge of the world (transcendence), the essence, or real, true form of some “thing” will manifest itself. Husserl’s method has been labeled as a philosophical, descriptive approach (Morse, 1992). He believed that his approach was the way to come to know some thing as it is, having first set aside the relationship of the

phenomenon to prejudice (historical tradition) or theories of the world. Husserl's four constants permeate his philosophy (Cohen & Omery, 1994). The first is his belief that his "anschauung" (German word meaning looking at or upon), or phenomenological intuiting, is the "ultimate test of all knowledge" (Ray, 1994, p. 138), and is a rigorous science. A study using the phenomenological method would not be credible or valid unless the researcher was first aware of its philosophical background and the analytic process of reflection. Phenomenology as it was intended is a philosophy, not simply a research methodology, involving stages of awareness, or consciousness, and setting aside prejudices and knowledge.

Husserl's second constant was "philosophical radicalism" (Ray, 1994, p. 137). He believed that "human experience contains a meaningful structure", with an emphasis on "essential structures of possible beings" (p. 137). "His eidetic, or descriptive, phenomenology sought universal essences, their structure and relations, based on the eidetic reduction." (p. 138). The "phenomenology of essences" attempts to discover absolute insights into the essence of whatever is given intuitively in an experience. The goal is to obtain a concrete descriptive analysis of the general essence of the phenomena being studied. The third constant in Husserl's philosophy is the "ethos of radical autonomy", the belief that as humans we are responsible for our culture and ourselves. The "respect for wonders" is the final constant. Cohen and Ornery (1994) quote Husserl, "The wonder of all wonders is the pure ego and pure subjectivity". This concept focused on self-awareness and awareness of others, or consciousness.

Phenomenological reduction is an important concept used by Husserl (Ray, 1994, p. 146). It refers to bracketing prior knowledge and prejudices resulting in a pure, naive

phenomena. The first stage of acquiring this natural or naive attitude is reducing facts to general ideas, accomplished by avoiding individuals or particulars. The second stage is actually bracketing, where the natural attitude is obtained. At this point the phenomena are unobstructed by prior knowledge and prejudices. Bracketing is an important concept of phenomenology that comes prior to obtaining data so that the true experiences, without the interviewer's bias, can then become known. By using this research method it is possible to note subtle experiences that have significance. *Lebenswelt* (German for life-world) is the world of lived experience that is so common that it is often overlooked but is nonetheless a significant part of a person's life (Cohen & Ornery, 1994).

Another key concept of Husserl's phenomenology is intentional consciousness, or directed awareness of some thing of the world. "The study of experience reveals consciousness" (Ray, 1994, p. 139). The experience of things include sensory perceptions (seeing, hearing, touching, tasting, and smelling) and other perceptions including believing, remembering, anticipating, judging, intuiting, feeling, caring, loving, imagining, and willing. The data, whether past, present, or future are captured and transcribed, then analyzed.

To intuit the meaning of experience of study participants during the interview process and descriptive portion of analysis the researcher brackets prior knowledge, prejudices, and future anticipations of some thing in order for the phenomena to show their meaning. Research questions are not predetermined in a bracketed interview. The interview flows from the initial analogy question ("what is it like to experience...?"). "Research or interview questions center around meaning" (Ray, 1994, p. 128). The

researcher then reflects on the described experiences and uses reflective insight (intuiting) to describe the essential structures of the phenomena.

This was a qualitative descriptive study, as is appropriate for entry-level researchers (Burns & Grove, 1997). The purpose of the study was to describe the barriers and facilitators of breastfeeding for active duty military women. Descriptive research “provides an accurate portrayal or account of characteristics of a particular individual, event, or group in real-life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorizing information” (p. 779). Qualitative research was appropriate because it had a broader scope than quantitative methods and prevented any subtle every-day life experiences from being missed.

CHAPTER FOUR - METHOD OF INQUIRY

Methodology

Chapter Four delineates the application of the qualitative descriptive method to the purpose of this study. More specifically, it addresses the application of the qualitative descriptive method, using Husserl's phenomenological approach, to accurately describe the barriers and facilitators of breastfeeding for primiparous active duty military women. This study used a descriptive phenomenological approach using the following outline of researcher activities delineated by Streubert & Carpenter (1995):

1. Personally describe the phenomenon of interest.
2. Bracket the researcher's preconceptions regarding the phenomenon of interest.
3. Interview participants in unfamiliar settings.
4. Carefully read the interview transcripts to acquire a general sense of the experience.
5. Review the transcripts to uncover themes or essences.
6. Become aware of essential relationships.
7. Develop formalized descriptions of phenomena.
8. Validate descriptions with participants.
9. Review the relevant literature.
10. Distribute the findings to the nursing community.

The researcher has personal experience as a primiparous, active duty military woman who is breastfeeding. Due to this experience, the researcher has preconceived ideas about facilitators and barriers to breastfeeding for primiparous active duty military women. Researcher bias was a potential problem in this situation (Sandelowski, 1986).

Husserl's method of phenomenology provides a remedy, called bracketing, for this situation.

The researcher bracketed (set aside) preconceived knowledge, bias, and beliefs relating to the topic being studied (research phenomena) to find the truth about facilitators and barriers to breastfeeding for primiparous, active duty military women, and to prevent the true experiences from being obscured (Streubert & Carpenter, 1995). All previous knowledge and experience the researcher has relating to the research phenomena was invalidated or suppressed continuously in order for the researcher to acquire the "natural attitude", the basis for truth and reality (Moustakas, 1994, p. 85). Everything that interferes with fresh vision was suspended. This was made possible when the researcher was able to sit in a quiet place and clear the mind by reviewing thoughts, feelings, biases, and ideas about infant feeding, and then set them aside (bracket). The researcher was able to naively and freshly learn about the experiences of these women, and continue to bracket these beliefs and preconceptions throughout the research process in order to obtain the purest description of the phenomena (Streubert & Carpenter, 1995).

The first and second stages of phenomenological reduction have been stated previously. Facts have been reduced to general ideas and prior knowledge and prejudices about barriers and facilitators to breastfeeding for primiparous, active duty military women have been bracketed. After bracketing was completed data was obtained. The researcher was the tool for data collection (Streubert & Carpenter, 1995). The researcher asked descriptive, open-ended interview questions in a semi-structured style, e.g., "How did you choose to feed your infant?" and "What did that decision mean to you?". These

types of questions allowed informants to tell about things that are important to them and the meanings that they attach to these things (Taylor & Bogdan, 1998). To facilitate the interview process the researcher asked some general, conversation-starting questions as a guide, and some more specific probing questions: a. What factors influenced how you chose to feed your infant, and b. When did you decide how you would feed your infant, designed to help the informant describe the phenomena being studied. Although research questions are generally not predetermined in a bracketed interview (Boyd, 1993), some idea of what to ask was necessary in order to conduct an interview that accomplished the purpose and had a conclusion. Having a guide for the interview was important to keep the interview on track, provide consistency, and as a reminder to ask certain things, especially for novice interviewers (Taylor & Bogdan, 1998) (Appendix C).

The purpose of the interview was clear to both researcher and informant and helped to maintain the focus on the phenomena being studied and to avoid misleading or confusing the informant as to the relationship between the researcher and the informant (Burns & Grove, 1997). Informants who asked questions about how best to feed their infant, or related topics, were referred to appropriate sources, and the researcher discussed these topics after the interview was completed, while walking to the car in order to avoid biasing the interview with the researcher's own views (Britten, 1995).

A pilot interview was conducted so that the researcher could hone her interviewing, intuiting, coding, and analyzing skills before beginning the actual study to ensure that the desired data could be obtained. The pilot interview was useful for checking the adequacy of the interview guide questions. The pilot interviewee was a primiparous colleague volunteer who met the research criteria. The researcher went

through the same procedure of explaining the study, obtaining consent, interviewing, and analyzing the data for the pilot interview as for the actual sample. A qualitative expert reviewed this data for the purpose of establishing content validity. The data from this pilot interview was rich and valuable to the study, and was included in the actual sample for these reasons by suggestion of the qualitative expert who reviewed the data.

Access

Participants for the study were obtained from a Pediatric Clinic of a large medical center on the East coast of the United States and had the endorsement of the clinic managers. Other appropriate institutional review board approval was obtained. More specifically, approval was obtained from the Clinical Investigation Division of the designated institution (Appendix D) and the Uniformed Services University of the Health Sciences Institutional Review Board (Appendix E).

Sample

To participate in the study, the informants were required to be primiparous, active duty military women whose children were between six and eighteen months of age. The sample was purely one of convenience, chosen for the proximity to USUHS, and the likelihood of finding an adequate sample. The sample size was identified as four to ten for this master's thesis. The sample size was dependent upon the number of women who agreed to participate in the study, time constraints involved in data collection, transcription, analysis, and possible early saturation of the data. According to Britten (1995) sample size in qualitative studies is determined by the depth and length of the interviews as well as what the interviewer is able to accomplish during these interviews. Because the interviews were of surprising depth and length, only four participants were

obtained. Saturation is achieved when no new information regarding the phenomena being studied emerges during data collection and analysis, or data collected earlier are repeated and confirmed (Germain, 1993). For this study saturation was achieved on most topics, but not all.

Informed Consent

Prior to each interview, the researcher explained the study and obtained written consent. Each informant was assigned a code number that was used instead of a name in transcriptions to maintain confidentiality. A master list of informant's names, contact telephone numbers, and their codes was kept in a secure locked box in the home of the researcher while the study was being conducted and was destroyed after completion of the study. The informants' names or other identifiers were not used in transcripts or in the final thesis publication. The researcher shared the findings of the study in written form with the participants by placing a copy of the completed thesis in the hospital library. The researcher contacted the informants at the completion of the study to provide them the opportunity to meet and hear a presentation of the findings. The researcher maintained audiotapes and transcripts in a secure locked box until the completion of the study. The audiotapes were destroyed after the transcripts and audiotapes were reviewed for accuracy.

Data Collection

Interviews took place in-person, in a quiet place convenient for both the researcher and informants. The researcher offered to bring a childcare provider, if needed, during the interview. The researcher conducted one interview per informant, approximately one to two hours long. The experiences of the women were probed until

the phenomena ("the thing itself" or the experience) was adequately described.

Interviews were audiotaped, transcribed, saved on a computer disk and printed on hard copy. The researcher did not take field notes during the interview but was able to summarize and restate the data to the informant during the interview to clarify the description of the meaning and to confirm that the data was correct. This gave the informants the opportunity to validate and confirm the meaning of their experience or make corrections. This technique lead to further discussion and richer data.

Demographic information such as age of informant and child, rank, race, and education level was collected during the interview as a prelude to the open-ended interview questions. These types of questions were easier to answer and facilitated the interview by allowing the informants to "warm-up" before being asked to answer more difficult open-ended questions. The demographic data was used to describe the sample in the conclusion of the study. A transcriptionist transcribed the audiotapes onto computer floppy discs. The researcher listened to the audiotapes and corrected the transcripts. The information was coded to protect confidentiality and was analyzed by repeatedly reviewing the data, highlighting key words and statements, then cutting and pasting the statements and key words under categories. This method has been employed by generations of qualitative researchers rather than use modern computer software due to time constraints.

Data Analysis

Analysis of meaning began with the first interview and continued throughout the study. The data collected was analyzed reflectively (reflective analysis). This involved describing meaning of experience, free from prejudices and prior knowledge, with

intuitive, reflective insight, similar to meditation (Munhall, 1993). Intuitive knowledge comes in the form of insight into one's consciousness after a period of "unconscious work", becoming so absorbed by the data that the researcher is able to reflect upon the data even while not consciously aware of doing so, until the essence of the phenomena is revealed. Reviewing the data repeatedly, or becoming immersed in it, helps to develop themes (Burns & Groves, 1997). Similarities in the essential experiences (themes) of the informants emerged from the data during analysis and reflection (intuiting). Similar data was sorted into groups, also known as "clustering". The researcher continually set aside prior knowledge and prejudices regarding the phenomena under study during the data collection and reflective analysis phases to allow the true meaning of the experiences to emerge.

Burns and Grove (1997) advocate that experienced researchers mentor novice researchers so that the intricacies of data collection and analysis can be best shared. Adequate application of bracketing, interviewing, and reflective analysis of the data were mentored by the researcher's committee chairperson and one adjunct research faculty member, both of whom have expertise in qualitative methodology.

Trustworthiness

"The goal of rigor in qualitative research is to accurately represent what those who have been studied experience" (Streubert & Carpenter, 1995, p.25). Trustworthiness is inherent to the philosophical underpinnings of this method when applied appropriately. Freedom from bias in the research process and its conclusions is called neutrality by Sandelowski (1986) and is the basis of Husserl's phenomenological method (Ray, 1994).

Credibility, dependability, confirmability, and transferability are concepts that must be addressed when demonstrating trustworthiness.

Validity, or trustworthiness, is an examination of the truth, believability, or accuracy of a claim (Streubert & Carpenter, 1995). Many strategies for assuring and assessing validity in qualitative research can be implemented. A researcher examines the representativeness of the conclusions as a caution against pre-existing bias on the part of the informants or bias generated by attention from the researcher. The researcher may affect the conclusions simply by her presence, and should be aware of the possibility (Burns & Grove, 1997).

The strength of the data was assessed by observing the source, the circumstances of data collection, and attempts by the researcher to validate the data. The researcher was cautious of the data, looking for evidence that it should not be trusted. The data was compared and contrasted for similarities and differences, and any significance noted in Chapter 5. Identification and examination of exceptions to the findings (outliers) test the generality of the findings. Repetition of findings within the same study, from another sample, or similar findings from independent sources, assures the validity of conclusions. The researcher constantly compared the conclusions for correctness (true experience). The researcher assessed the data for evidence that disproved the conclusions. For the most complete verification, the researcher sought feedback from the informants concerning data and conclusions throughout the study and after its completion. Informants confirming and validating the data and conclusions establish credibility. The conclusions are credible when the informants can recognize the data as their true experiences (Sandelowski, 1986).

Dependability refers to obtaining the same findings if a study is repeated and is assured by obtaining credibility of the findings (Burns & Grove, 1997). It is similar to reliability and consistency in quantitative research. Dependability, confirmability, or “auditability” can be documented by an “audit trail” where the data and thought processes that led to the conclusions are recorded (Sandelowski, 1986; Burns & Grove, 1997). These were documented by audit conducted by an experienced qualitative researcher not involved with the study. A nurse researcher who is an expert in qualitative methodology reviewed all transcribed data to ensure trustworthiness. The ability of the study findings to have meaning to other people in similar situations implies transferability, or “fittingness” (Sandelowski, 1986).

CHAPTER FIVE - STUDY FINDINGS

This section presents the results of data analysis using a descriptive phenomenological approach. It includes a brief description of the sample and the findings are grouped according to themes. The themes emerged from analysis of significant statements where redundancy or saturation was achieved.

Description of the Sample

The sample consisted of four primiparous active duty military mothers with an infant between the ages of six months and eighteen months. Two participants were in the Army, one was in the Navy, and the remaining participant was in the Air Force. Two participants were registered nurses, one was a nurse anesthetist, and one was an attorney. Three participants were at the O-3 pay grade and one was at the O-5 pay grade. Two participants met their feeding goals of feeding for at least six months, successfully breastfed, and two did not meet their goal of breastfeeding for at least six months. All the participants were married. Each participant was Caucasian. Their ages ranged from 28 to 42 years. The common themes of their facilitators and barriers of breastfeeding are described as the findings.

Findings of the Study

The findings of this study presented in the following table (Table 1) concisely illustrate the facilitators and barriers of breastfeeding. Each theme category contains a brief description of the theme followed by examples of significant statements representing each theme cluster. A general theme of different types of support was evident throughout the interviews.

Table 1
Categories of Themes and Theme Clusters

Theme Category 1: Support

Theme Cluster 1A: Husband, Family, Friends

Theme Cluster 1B: Health Care Provider

Theme Category 2: Support Going Back to Work

Theme Cluster 2A: Emotional Environment

Theme Cluster 2B: Physical Environment

Theme Cluster 2C: Pumping is a Chore

Theme Cluster 2D: Desire for Extended Maternity Leave

Theme Category 3: Discontinuation or Continuation

Theme Cluster 3A: Commitment

Theme Cluster 3B: No-one Else Can Do This

Theme Cluster 3C: Expectations to Succeed

Theme Cluster 3D: Knowledge to Practice Deficit

Theme Category 1: Support

Theme Cluster 1A: Husband, Family, Friends

The women expressed that the husband is the key to support of breastfeeding. They expected support from their husbands. One participant stated she received positive reinforcement and reassurance from her husband; she also stated, as did the other three participants, that her husband gave subtle pressure to quit breastfeeding and to substitute with formula. For the most part husbands preferred to avoid disagreement with their breastfeeding spouse saying, “Whatever you want, honey”. Understandably, the participants expected a different level of support, especially from their husbands. All

family members seemed to think they were helping, by giving well-meaning advice to the new mothers. They were actually adding to the stress by providing negative pressure, which consisted of subtle and sometimes overt pressure to stop breastfeeding.

The participants also commented that family members and many friends encouraged them to quit breastfeeding when they spoke of difficult situations. They did not provide positive encouragement for the breastfeeding women, but more of a backhanded support, “You’ve tried, give it up, give that baby a bottle”. The participants were seeking support and reinforcement. They didn’t hear that they were doing a good job, except in one instance. None of the participants were part of a support group or participated in LaLeche League activities, where they would likely have received support and reinforcement. Several participants found the support they needed with lactation consultants. These women were susceptible to the negative pressures to quit breastfeeding and needed much more positive reinforcement to facilitate continuing breastfeeding. Support from husbands, then family members, then friends was ranked by level of importance to the participants.

Participant # 3. ...If I had said, “nope, I only want to bottle feed” he (husband) would have said, “okay-that’s great”. Or “no, absolutely I only want to breastfeed”...he would get up, without my asking, he took it upon himself to pick the baby up, he would change the baby-new diaper and bring the baby to bed for every feeding, even during the night...he was really wonderful about it, he helped as much as he could and he was very supportive...getting me things to drink and getting pain medication for engorgement, starting a hot shower for me or bringing the baby to me. It was more action oriented...Being a male...just being very loving, very supportive... I had a lot of emotional support from my family and friends and from my husband and stuff but what do they know about breastfeeding. They’re not there to help me do it. I have a good friend who is a pediatric anesthesiologist, he knows what to do if anything happens to the baby, I’d feel good about leaving him with them...this was the first time I actually felt good about giving him a bottle. He said, “breastfeeding is good, but there’s something to be said for a well rested mom”...that’s not a bad thought...almost three weeks I struggled with breastfeeding and I finally felt like I had the green

flag to say, I'm not going to hurt my baby because he had already gotten the colostrum, he had already gotten some of the antibodies and If I only do it for a few months - I only do it for a few months, ...I have a girl friend who said --and sometimes people who aren't empathetic by nature, she's a nurse-interestingly enough she's a NICU nurse and she was like, "Re-eeaaally? You didn't have enough milk. Oh my god, my kids used to choke all the time because I had so much milk". I'm thinking, "I already feel bad as it is. Please don't make me feel worse". I have one sister... who said, "you've given it that old college try, why don't you just go with the bottle...and my other sister, I helped her breastfeed her two children. She said, "I can't believe you're giving up breastfeeding, you were after me for so long to breastfeed, breastfeed, it's the only way to go"...another sister who had had breast surgery so couldn't breastfeed said, "Oh, just bottlefeed"... "Do what works for you but don't spend a lot of, don't waste any sleep trying to breastfeed". It was my husband who was very supportive of what I chose to do. Anybody else who hadn't had a baby and hadn't breastfed, were like, "if it works, it works, and if it doesn't go to a bottle"

Participant # 2. My husband – certainly. I know he's concerned..."You need to, you've done a great job. If you want to quit, I'll support you. I love you for it, for that. I can't believe what you've done."...a goal that we share. I think that builds a personality and a character for a baby and it may explain for him so that he understands a little bit more...he says, "I totally support you in what you want to do...My mother said it to me too "Hey, you've got six months on board, he's doing great. Give it up. It's killin' ya". It's not killing me but I need to talk about it still. This hurts. Sometimes I have a lot of anger..."Just quit. Six months is good and even then at four months it's wearing you out, you need to think about quitting"...Of course my mother is not the most influential person in my life, but of course she is my mother. I want to please her...I've been upset with her because she doesn't understand...I'm telling her what's going on in my life, the baby, breastfeeding, maybe work, and transitioning out of the military. She's definitely an influence.

Participant #4. My husband wanted me to do what I wanted to do...He just thought, "No problem". I don't think he cared whether I did it one way or the other. Except that in the beginning the doctors recommended doing it because he was premature..."whatever makes you happy". I had friends who nursed, but no one really... My mother fed my brother and I both with bottles. My sister-in-law recommended the first six weeks...She even had big red circles on the calendar at eight weeks and she would X-off days.

Participant # 1. My husband - probably not as much as I would have liked...there was even a time where I was just feeling overwhelmed...one time I said to him, "you know I'm having a difficult time with this" and "I really need your support on this". And it never came. He would try to do other things, it was hard... You're trying to do everything. You just never had twenty minutes...you come home and the kids have been home from school, they have all their questions and

everybody wants to eat dinner...My husband would try, but usually he would get home after I would...I don't think he could have done anything to make me feel better. He wasn't sure what I wanted; I don't think he knew if he really should push breastfeeding and the pumping business for fear that maybe I really didn't want to be pushed..."I support you in whatever you decide to do". . .I'm just the kind of person who tries to do it all anyway rather than ask someone to something else. He was supportive in his own way, but it just wasn't...he didn't know and I really didn't know what I wanted...I don't how much support a husband can give...The first few days, even the first week, I probably would have quit if I hadn't known from other people, just my friends saying "get through the first couple of weeks, it'll get better"...I don't have any family other than the immediate family besides my dad, and that's not really something you discuss with your dad. I'm not close to my in-laws, so there wasn't really anyone in the family to discuss and confide with. My friends were my family so that's where I got most of my support and guidance.

Theme Cluster 1B: Health Care Provider

Health care providers have influenced each of the participant's decision to breastfeed and to continue or quit breastfeeding. The participants brought to light issues of trust, sincerity, kindness, gentleness, and knowledge. They have done this through listing the benefits of breastfeeding for infants ("The Party Line"), by occasionally giving positive reinforcement (which pleased the participants), and by providing subtle and sometimes overt negative pressure. The participants were focused on one marker event: weight gain as an indication that their baby was doing well. The participants seemed to be crying out for positive reinforcement, and not getting it from their health care providers. One participant was convinced her baby was a poor breastfeeder, and used that as a rationale to ultimately quit breastfeeding early. Participants reported being given permission to quit breastfeeding from an external source, making it acceptable then to stop breastfeeding. According to the findings, health care providers are the not the best supporters of other health care providers who are trying to breastfeed. Each participant stated that she did not receive enough postpartum support and education about

breastfeeding from the regular postpartum nursing staff while in the hospital. The participants whose infants were in the Newborn Intensive Care Unit (NICU) received assistance from the NICU staff, but none from the postpartum staff. The reasons for this are unknown. Perhaps it is because three of the four participants delivered and were discharged over the weekend and the staff had little time to spend with these new mothers. Or because the new mothers were health care providers the staff may have presumed that they must already know how to breastfeed.

The participants expressed that breastfeeding went well when in the presence of a lactation consultant, perhaps because the participant had a feeling that everything would be all right. They would be able to breastfeed well due to the presence of the lactation consultant, causing the baby to be more relaxed. The participants stated that lactation consultants gave them practical help, from covering the patient workload during a pump break to giving practical tips on breastfeeding techniques. Another thing lactation consultants provided consistently and readily was positive reinforcement. The participants sought reassurance and positive reinforcement.

Participant #3. ...This nurse who came kicked everybody out of the room. She said; “we’re going to breastfeed”, she was like an angel, old, grandmotherly type. She got the baby set to breastfeed, it was the first time he really breastfed well and I really felt like I did okay for the next two feedings...We’d bring him back to the doctor and the second time we brought him back he said, “bring him back in a couple days and if he hasn’t gained any weight in a couple of days, we’re going to do a metabolic work-up on him”...my son gets stuck with needles for something that I know is related to my inability, or our inability to feed...I know there’s nothing inherently wrong with him and I wasn’t going to take that...except for that one nurse, I got absolutely no support when it came to breastfeeding. Because you’re in and out of the hospital...in at eleven o’clock at night on Friday night and I was out by Sunday morning. I didn’t have a very good breastfeeding experience...I think there was a lot of education, a lot of really true factual stuff that they could have taught in the hospital that they didn’t...I had a very good girlfriend who was a lactation consultant...She’s a very gentle woman, pulled his arms back like a chicken and then when he cried and opened his mouth to scream she just pushed his face onto my breast...that’s sometimes what you have to do,

and he breastfed fine then...she's a very gentle person...the baby didn't know what to do...My lactation consultant said this is a learned behavior, you will have to teach him how to breastfeed...I thought she actually made me feel good that I was actually doing the right thing. You're doing fine...really? I thought her input was invaluable. I would encourage somebody to get in touch with a lactation consultant and I think what we need to do in the military is to either have the lactation consultants or have them do home visits...

Participant #2. It's part of what I do, what I chose to do and there's a couple lactation consultants that totally support me as well..."go pump and I'll take care of your patient as well". I had a clinical nurse specialist who is also a midwife who walked in on me the other day... She was shocked that I was pumping... "I can't believe you are still doing this. How are you finding the time, how are you continuing your milk production?...Everybody says, even the doctor said, "You might need to quit breastfeeding...This is a really serious infection. I can't tell you how many people would just quit"...I talk with doctors and they go "Oh, is he formula fed?" I go, "No, never an ounce! He gets breastmilk only." The look on their face is just amazement. That's a very big high for me. I always look forward to that question. Is he formula fed? No, no. I get more of that maternal feeling, like I'm succeeding.

Participant #4. They are really helpful...you can call all the time and ask them your concerns and they also have a support group if you want to talk to other moms about problems you've encountered. When I was having problems I had spoke to the lactation consultant, but not military. Just civilian...he had problems with his latch-on and all that stuff...they were very nice and very supportive... The lactation consultants were the folks I rented the pump from in the beginning then went back to them when I had problems. They were great. You could go every Tuesday and Thursday, they had a doctor's scale, so if you wanted to make sure you were feeding him enough, if you were nervous...they were really helpful...the NICU recommended breastfeeding for his health. They gave me a pump from the hospital to use, and I actually brought milk back and forth to the hospital, and rented a pump...I spoke to my O.B., and she said, "Well, as long as you keep pumping regularly your milk doesn't dry up"...The staff in the NICU were incredibly supportive, they had pumps there and separate rooms back there where you can go during a visit and pump, and they had freezers there...they really pushed it.

Participant #1. Whenever I went in for my prenatal stuff, they always asked have you decided to breast or bottle feed, and they always said "Oh, that's good. "...I know that healthcare providers in the military seem to be supportive of breastfeeding. You go to the clinics and see the posters on the walls in the exam rooms promote breastfeeding. I don't think there was good teaching care postpartum...The care that I received postpartum in the military facility, I don't think that anybody even looked at my breasts. They asked me how I was doing...

is it sore because it's supposed to be somewhat sore?... the NICU nurses were very good - I had to go to the NICU when I was breastfeeding. A couple of them were very good, they would watch me and the baby, and they would give pointers. The postpartum people never once watched me feed the baby, they never once looked. My nurse brought me a tube of lanolin and that was it. That stuff's worthless, that stuff's awful. I gave birth early Friday morning and then I was discharged on Sunday. I really was in the hospital on the weekend, so I don't know if I had been there during the week if that would have been different...If somebody would have come around, I don't know if the lactation consultants actually came around and visited people or if they only do it if you ask for help. I knew there was a piece of paper you could fill out and they would call you at home and see how you were doing, which I didn't bother to do.

Theme Category 2: Support Going Back to Work

Theme Cluster 2A: Emotional Environment

A serendipitous finding was that of the three participants working in the health care field, none reported support from usual health care coworkers. They consistently put up barricades to breastfeeding, provided negative pressure, subtle pressure to quit breastfeeding and switch to formula, purveying the attitude that an unhealthy smoke break is an acceptable reason to take a break, while taking a pump break (a healthy behavior) is a special privilege, and that breastfeeding is something of which to be ashamed. One participant perceived jealousy from some of her coworkers who had opted not to breastfeed or who chose to quit early. If support was given it was usually passive support. The lack of support of the coworkers may have been actual or perceptual, based on perceptions of time and resentment. This was quite possibly situational, being affected by individuals, workplace, and personalities. One participant summarized the consensus of the health care provider participants "The talk was there, but the walk wasn't." Supervisors of the all participants were not actively supportive of breastfeeding, but passively supportive. They did little or nothing to take down barriers to breastfeeding in the workplace and smooth the way for the breastfeeding employee, although they did

not put up roadblocks. Breastfeeding mothers need more active, open support for breastfeeding as well as positive reinforcement. By doing so they are banking on the employee's future productivity by preventing missed work days and exclusion from day care due to illness,

Participant #3. ...Despite the fact that their philosophy is, or their goal is to render care to people. They're really not very nice to one another in medicine... once you go back to work...I don't know that anybody would have looked favorably on..."I need a half an hour break to go pump and store milk, and do that twice a day"...I feel like that as an active duty woman it is something I should be entitled to, but it wasn't the case...I would have had to ask for a break which I think they would have done because I think that there is sort of that fear among people who are not breastfeeding, "if I say no or, if I don't support it then I can get into trouble". I think that they would have been supportive if you directly asked them, there may have been some underlying resentment..."she's getting three breaks a day instead of two breaks a day".

Participant #2. No one's made it past four months, so I think that sends a little message...I said at the beginning, "I have to have time to pump, sorry"... It amazed me there were actually people that gave me crap about that...nobody would say "no you couldn't do this", it was just the looks. I overheard someone saying, someone asked, "Oh, where is she?" "Oh, she's pumping". I came around the corner hearing that...the connotation that I'm getting something more than someone else is, a break...smokers get whatever break they want. It amazes me that three people sneak down and have a cigarette break and nobody looks at them. I go to pump, and I'm in and out of there in 15 minutes flat, usually, and I get this crazy look like I'm trying to take advantage that I have to pump. I think that there's a jealousy issue because I think a lot of women wanted to continue breastfeeding...It depends on who's working that day and it directly affects what my day looks a lot...It depends on who's on, sometimes lots of support and sometimes not...I think that a lot of people have been ashamed...they say, "Gosh, you're still doing that? Aren't you tired of it?" I want someone to say - "Boy, you're doing a good job. You should be proud of yourself." You don't get that, you get the amazement but you don't get "Wow! You're doing a great job!" My boss, I think that she wouldn't dare say you couldn't. She wouldn't also say a message to everyone, "Hey, she needs to pump make sure she gets the time to do it". It's not that extreme but it's your own choice and you need to be able to find the time and you can't make it a half an hour thing, several times a day...a lot of people were doing that and I think that's why the stigma came with me...I don't think anybody ever expected it to go on this long either.

Theme Cluster 2B: Physical Environment

Only one participant related that she had a supportive physical and emotional environment for expressing breastmilk in her workplace, to include time for pumping, and active support from the people around her, although her administration took a passive support role. Interestingly, this participant was the only non-health care provider. The rest of the participants described uncomfortable environments for pumping that lacked privacy, aesthetics, electrical outlets, time to pump, and someone to cover their workload while the mother was taking a pump break. They expressed stress at trying to adequately express breastmilk during a too-short break.

Participant #3. I used to see active duty women in the bathroom stalls pumping on their ten minute breaks and that has to influence you a little bit, at least leave an impression in that, I thought, “Wow, I don’t know if I could do that, or can’t be easy.”...there’s nothing attractive about having to go in the bathroom stalls, sit on the toilet and pump your breasts. There’s no privacy. You go to a female locker room, there’s no place else to do it except in the bathroom stall. The mechanics aren’t very easy. I’m not sure that the environment really supports it.

Participant #4. I was in a really good situation. I could shut my door, lock it and work on my computer and talk on the phone while I was doing that.

Participant #1. ...I’d like to see places for breastfeeding, pumping at work but I’m not real hopeful in the military, which doesn’t have any real great facilities anyway. I don’t see them in these days doing anything to make a difference. But at least a supervisor might be able to set up a private area - a little storage area that’s not used. It might be on you to maybe do what you can to brighten it up a little. But at least if a supervisor can provide an area, then you have a responsibility to do your part and compromise and make it a nice area for yourself.

Theme Cluster 2C: Pumping is a Chore

Some of the participants found incorporating pumping into their daily lives easy, part of their life, while others found it to be big hassle, time-consuming, and demanding. All the participants reported feelings of anger, frustration, and guilt in regard to pumping.

One of the participants mentioned she felt a sense of accomplishment knowing she had pumped enough milk to feed her infant while at day care the next day. Another participant noted she thought pumping was a huge burden, an extra chore tacked onto an already long list of things she needed to do every day. The participants felt that pumping was all they were doing, and that they didn't get a break between meeting demands of family, work, or school responsibilities. Although both these mothers expressed that feeling, one mother was able to find something positive about pumping the breastmilk, and all the others found something negative about the daily pumping routine. All the mothers stated that expressing breastmilk with a breastpump was the means for them to continue breastfeeding their infant and providing their infant with good protection and nutrition.

Participant #3. I was using the mini-pump and I was using it so much because he wasn't feeding well and I wanted to continue with the demand. The motor was going on and on..like the motor was dying.. I was using it every couple of hours. I used to sit with my double cup breast pump on, a half an hour would pass and I would end up with an ounce of milk.

Participant #2. ...The pumping, it's gets old...there are definitely times when I go five hours...I think I've gotten better at it, saying I need to pump. It's part of what I do, what I chose to do...I get more of that maternal feeling, like I'm succeeding...One more day, look at what you did, you did a good job. You made all the milk you needed to make...
It's just a feeling like I accomplished something in itself...I feel very good about myself and I'm doing a very selfless thing. Sometimes the pumping and the breastfeeding just teeters me on edge...I need a break and then get back at it again ...It gets out a little bit of animosity, so that I don't feel so uptight. And it's just life. It makes you feel like you can't do anything else but just pump and get it over with, and get back.

Participant #4. I hated it, it was just a pain in the neck...I really did not like pumping...it's just not fun! I was pumping more than I was nursing. I was pumping three times a day and nursing once during the week and if I had an especially demanding day, that's all I was doing...It's harder for others who don't have a private office. It's still doable. Lots of times you go into the bathroom and hear -shh-shh- so you knew what they were doing in the bathroom. I can't

imagine any other situation other than being at home where I didn't have to pump, that I could have done, definitely...I would have to pump so he could nurse...he would nurse and then I would have to pump again because he was only nursing for one or two minutes. It was just an ordeal. He was eating every three hours I was always hooked up to something.

Participant #1. I always felt like I was being rushed because I didn't want to miss anything. We only had a ten to fifteen minute break and that really isn't enough time to do everything you need to do to pump well...it seemed like I was never getting a break. Any break I had during work, I was pumping...It just really wasn't enjoyable...pumping started to become a chore as well...It was one more thing on the to do list...Actually it made it difficult too, it was less convenient...with formula you could mix it up ahead of time even the day before because it would last for two days and I could have the bottles ready to go and not have to wait until nine o'clock at night or so to fill up the last bottle for day care...The reason for stopping was because the benefits were no longer as important as the inconvenience of it became; that outweighed the benefits to me. The scales tipped...I didn't have the time to sit there and pump...if you're talking about military people going back to work then you would have the issue of getting them a pump, which costs money.

Theme Cluster 2D: Desire for Extended Maternity Leave

Three of the four participants remarked that they either took more time than the military normally allows for maternity leave, or would like to have taken more time to spend with their infant prior to returning to work. Some expressed the perception that it was acceptable to breastfeed until they went back to work. To breastfeed correctly, they needed to do it all the way or stop all together.

Participant #3. Once I delivered, I was off for six weeks...I ended up taking regular leave in addition to maternity leave and then was PCS-ing, transferring at the same time so I got house hunting time...though I was on active duty basically I stopped breastfeeding the Friday before I went back to work. It ended up being for two and half months I breastfed while I was on the combination of leave, house hunting and maternity leave, so I never did try and work and breastfeed.

Participant #4. They gave me six weeks and then I took an extra two weeks. I wanted to have six weeks with him at home, and my boss said I could have as much as I needed, I took an eighteen days extra days to be with him at home. Then I got out in January so I could spend more time at home with him.

Participant #1. Initially I thought I was going to have to go back after two or three weeks and so I needed to start him on the bottle as soon as he was born. I had read that it would take a couple of weeks to get the baby used to the bottle. I would love to see maternity leave even a little bit longer - at least eight or twelve.

Theme Category 3: Discontinuation or Continuation

Theme Cluster 3A: Commitment

The participants all verbalized an underlying theme of their commitment to their infant. They also expressed their commitment to breastfeeding and expressing breastmilk for their infant. The participants illustrated in this section show how much they are committed to breastfeeding and providing breastmilk for their infant while suffering, blows to common dignity and various personal sacrifices. One participant spoke about spiritual well-being associated with breastfeeding.

Participant #3. I knew I was always going to breastfeed, at least try it, having been somebody who taught breastfeeding classes I always thought it would be great to breastfeed. I just knew I always would do it. I was not thinking, "I absolutely can only breastfeed-it's the only thing I can do". I wasn't sort of militant about it. I just thought I would try it and I did. I would love to have breastfed for an entire year but I did not have a great experience breastfeeding... It's not that I wasn't committed to it, but it was so difficult in spite of my training and so I quit. I don't think you should be a breastfeeding nazi about it but I think you owe yourself and your baby as much opportunity to be successful at it...if I were to have a baby now, I would probably really get more committed than I was.

Participant #2. ...I was always going to breastfeed and I think that that come from my mother because when we were younger, I always knew...she always talked about it like when you breastfeed your infant...It was always in my mind. Plus my sister, people that I know...at first, the whole aspect of using my breasts for feeding was a very big barrier...for me the choice wasn't really there. I had to give up whatever barrier because that was the best thing for my baby...There are so many things that play a role in the continuation of it that if I had not said right at the very beginning, "I am going to breastfeed for at least a year, there is no reason, there's nothing that is going to sway me, nothing, no matter what!"...I've been given the choice to continue...it's almost like it's a re-commitment to him. I'm committed. It fills my cup every day to be able to say and look at everything that I've done and say, "This is wonderful, look at this baby, it's your life."

Participant #4. There was really never the kind of question of him not breastfeeding, and that if it didn't work out I was going to switch. I just kind of got into a routine and that's why initially six months was...except between six months and a year is nice but it's not really necessary...Not much more beneficial than formula. I don't think I ever made the decision...It was just something that I assumed I'd do...It was just kind of the assumption that I just could see how it worked, something I planned on doing...

Participant #1. I had originally hoped when I was pregnant, my expectations were, a year I will breastfeed. As I got farther on, I thought if I can get through six months then that will be good...I used to think I was a pretty tough person and I could do all this...the number one reason to breastfeed in my opinion was the benefit that breastmilk could give the baby. Everything else put aside, that's it. If it weren't for the benefits, then I wouldn't have done it...

Theme Cluster 3B: No-One Else Can do This

One participant enthusiastically described the health benefits that she and her child received by breastfeeding, in addition to the special bond between them. Two participants elucidated very nicely that breastmilk is a special thing that only a mother can provide for her child. Also mentioned was the special, comforting relationship the breastfeeding mother has with her infant.

Participant #3. ...It is your one opportunity you can do something for your child...

Participant #2. All the benefits are there... the best thing I could do for him would be to breastfeed him...The bond, like when he snuggles in like that, I'm everything to him...feeding is a whole learning process... they're looking around trying to see everything, they still want to eat...It's more of a time issue. But with a bottle, they just suck it down and then they're done...breastfeeding is a social thing for them, they interact with you throughout the whole thing, they'll talk with you, and smile at you, look around. With a bottle it's just a means. It takes so much longer to feed, he's always been a slow eater, but now he pats my breast, looks up and stops - checks me out and he goes back to it. Very interactive... That meaning, that patting, playing with your mouth, patting your face, mess with my hair...then when he's taking the bottle he's not really like that. Towards the end, he kind of looks at you like, oh ok; you're still there...Anybody could feed him with a bottle...I'm giving A. (the baby) the best I can give him. You're their life right now. I wouldn't deny him of that...he's doing fine, and feeling like my baby is growing, that's a real big high for me...It takes a lot out of you but the benefits outweigh the tiredness, outweigh the pain...your child is healthy because

you're feeding them the ultimate healthy food...I didn't bond with him until really when they put him on my chest and he started trying to breastfeed right away. That was really amazing thing to me. Breastfeeding has allowed me to feel I'm living for the baby, for his eating right...the benefits to myself, every night I can have brownies...Taking on the challenge that no-one else can do.

Participant #4. The nurses said it was better for him. They said your body knows the baby was born premature, it makes a different kind of milk for the premature babies, which formula can't give the premature baby...I miss him, nursing at night or if he's crying hard and I can't give him my breast...The negative (to stopping breastfeeding) is emotional. Part of me wishes that I had kept nursing for one more month...he's a baby, he's still only fourteen months, but when he tries to grab at your nose or your ears, you know you're a mother. It's very cute.

Participant #1. It makes you feel like you're doing something special that nobody else could do for the baby...everybody can give the bottle to the baby, but in terms of the breastmilk that's the only thing that makes you special...

Theme Cluster 3C: Expectations to Succeed

The participants expressed varying expectations of themselves about breastfeeding prior to giving birth. Their decisions were based on general knowledge, knowledge of benefits of breastfeeding to infants, family experiences, or personal assumptions. The participants discussed the expectations they had for breastfeeding and for themselves regarding breastfeeding.

When the participants of the study initiated breastfeeding with varying amounts of prior knowledge of breastfeeding, accompanied by varying expectations of themselves with regard to breastfeeding. Three of the four participants had high expectations of themselves for breastfeeding. Whether that is because they are women, or women as well as health care providers, and because they had some prior knowledge of breastfeeding is unknown.

Participant #3. I consider myself very knowledgeable about breastfeeding...I helped hundreds of women breastfeed...I didn't want to bottle feed him...It's easy you just read about breastfeeding, you go to classes, and the baby knows what to do, that's what everybody says...you will have to teach him how to

breastfeed...my senior project at nursing school was breastfeeding. I had higher expectations for myself than I did the average woman...you have this idyllic version of this wonderful breastfeeding baby, you pick him up and put him to the breast any time, any place, any where...I helped hundreds of women breastfeed, I know all the tricks...if you're not used to failing at something and you think you're pretty well prepared to do something and you try to do it and you really do fail...

Participant #2. In studies, if you can get to six months you give the baby all that it needs. Now you're just adding the frosting on the cake...

Participant #1. I just know it is the recommended thing for an infant, it's the best thing for the infant. It has immunological properties in it that formula can't give...I knew that the immunological properties and other types of growth and development, it was better, breastfeeding promoted that...I knew he would be going into daycare after six weeks at the end of my maternity leave, so I knew that he would have some protection from all the colds, ear infections, and stuff at the daycare. I don't think anyone will argue with breastfeeding is the best and before they go back to work, at least do that, I think that there's benefit there. For all those reasons that we've talked about, I think - the benefits to the baby - the interaction, some of the little touchy, feeling nice feelings you get about yourself for doing it...once they get back to work, it's hard.

Theme Cluster 3D: Knowledge to Practice Deficit

The participants supposed that because they had knowledge of breastfeeding, they would be able to put it into practice easily. A recurring thought the participants expressed was "I should be able to do this". They took on the burden of guilt that it was their fault or their problem if they were not able to breastfeed. They spoke about the difference between their prenatal fantasy of breastfeeding, and the realities of the pain, frustration, and feelings of inadequacy while teaching an infant how to breastfeed. They spoke about different temperments of infants and how some infants pick up breastfeeding quickly, and others require a lot of teaching. One participant remarked about the inconsistency in breastfeeding her infant. She never knew if her infant would cry continuously or would settle into breastfeeding quickly at any given feeding. One woman commented that she could control everything in her life except how her

responded infant while breastfeeding.

Participant #3. ...I consider myself very knowledgeable about breastfeeding...I breastfed for the first time in the hospital and thought it was not going to be difficult to do...Then I went home and then I really couldn't get him to breastfeed. Sometimes it took me forty-five minutes to get him latched on...he was having problems with weight loss...I didn't want to bottle feed him. I didn't want to start the vicious cycle and so the first night or the second night I can remember getting up in the middle of the night and being hysterical, crying..."I'm starving my baby"...the baby was screaming, I was upset and I just could not get him to breastfeed...when he finally would latch on - it was extremely, extremely painful...one minute he would breastfeed fine, and the next breast he wouldn't latch on at all...there was no pattern to it. I became a bottle and breastfeeder and he was gaining weight, of course. Then the only time he seemed to be satisfied is when he was drinking from the bottle...I never really got an adequate supply, of milk...I think it was the old vicious cycle, as soon as I introduced the formula, the demand wasn't there...it was really discouraging. It was more of a disappointment than I imagined that it would be...Because I really did want to breastfeed...I'm an educated woman with one healthy baby...sometimes he would breastfeed fine, he would get right on the breast and other times he wanted nothing to do it. Finally, the Friday before I went back to work he pushed me away as if to say, "well come on, we've tried this for two and half months, you didn't do real well and I really didn't do very well, you're going back to work, so let's just call it quits"...it was a toe-curling experience with him latching on...maybe I wasn't drinking enough for awhile...you feel bad again, "wow, what have I done?"...Why didn't I stick with it...I had the knowledge to do it...I should be giving my baby the best nutrition, the best immunity and subsequently he has had a lot of ear infections...you feel like a failure...you should be able to...A month later, two months later, I thought, "wow, I wish I was still breastfeeding"...at that point, you can't really do anything about it. You just hope you learn from the experience and maybe approach it in a different light...It's sort of a shame but what are you going to do?...You begin to think it's you...You think, it can't be him, he's just a newborn baby...I felt inadequate...it was probably the most depressing thing on my mind...this little infant can turn an otherwise confident, successful woman into this bag of nerves...You can actually feel your hands get sweaty...the only thing I didn't have control over was my baby...I could position him, stimulate the breast, not stimulate the breast, increase my flow...I had control over everything but I didn't have control over how my baby was going to be...I knew all the stuff that I was supposed to do and I was just such an utter failure...

Participant #2. It was easy; he did perfect for me. He got into a schedule right away, and started gaining weight we had no problem with it...the offer of the clothing helped me be comfortable...if I didn't feel comfortable, I think it would have hurt me as far as more tying me down...That pillow made my life so much easier...actually guide the breast there...I had the freedom to sit down and be

really relaxed and I could get my milk to let down quickly...I was still worried that he was going to be something wrong with him. I still thought he was going to be three pounds, and when they put him on my chest and he automatically went for my breast, I thought, "This is my baby, I can do this."

Participant #4. He was born early, almost two weeks, and was in the NICU. I was planning on breastfeeding him but the NICU recommended doing it for his health. I was making too much breastmilk...I was feeding him from a bottle, and wanting to teach him to nurse...once we got the hang of it, it was time for me to go back to work...it only took a couple of weeks to get it down...It was worth it.

Participant #1. ...Initially I thought I was going have to go back after two or three weeks and so I needed to start him on the bottle as soon as he was born to get the baby used to the bottle. I started right away, and I would pump and put the milk in there...I think it was a lot of nipple confusion and it was somewhat frustrating...I think it was weaning me, not him.

CHAPTER SIX - IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSIONS

Implications

Active duty women in the military are choosing to be mothers and breastfeed more than in the past and there is little knowledge of breastfeeding practices for this group (Corbett-Dick & Bezek, 1997). According to Surgeon General C. Everett Koop, society and health care providers must acknowledge and prevent barriers to initiation or continuance of breastfeeding, (1997). The research on working mothers repeatedly finds returning to work a barrier to breastfeeding (Auerbach, & Guss, 1984; Loughlin, et al., 1985; Madlon-Kay & Carr, 1988; Ryan & Martinez, 1989; Janke, 1993; Miller, Miller, & Chism, 1996; Corbett-Dick & Bezek, 1997). Active duty military mothers who breastfeed have been studied very little; of note is one published study (Madlon-Kay & Carr, 1988) and an unpublished study of active duty and family member breastfeeding mothers (Kugler et al., 1994). The experience of choosing how to feed their infant and the barriers and facilitators of breastfeeding for primiparous active duty military mothers is relatively unknown.

The findings of this study, as shown by participant statements, parallel and support the findings of other studies in the literature. What are barriers and facilitators of breastfeeding for primiparous active duty military mothers? A major theme that emerged from the data was the support necessary for the woman to initiate and continue breastfeeding. If support was plentiful, it facilitated the woman continuing to breastfeed longer. If support was not available the women stopped breastfeeding sooner. Support takes on many shapes for the breastfeeding woman, physical and emotional accommodations, and supportive attitudes, both expected, perceived, and actual. The

spouse was seen as the major support of the breastfeeding process, followed by friends, and family. This leads to speculation of added difficulties a single mother must experience. This general theme is illustrated in Figure 1.

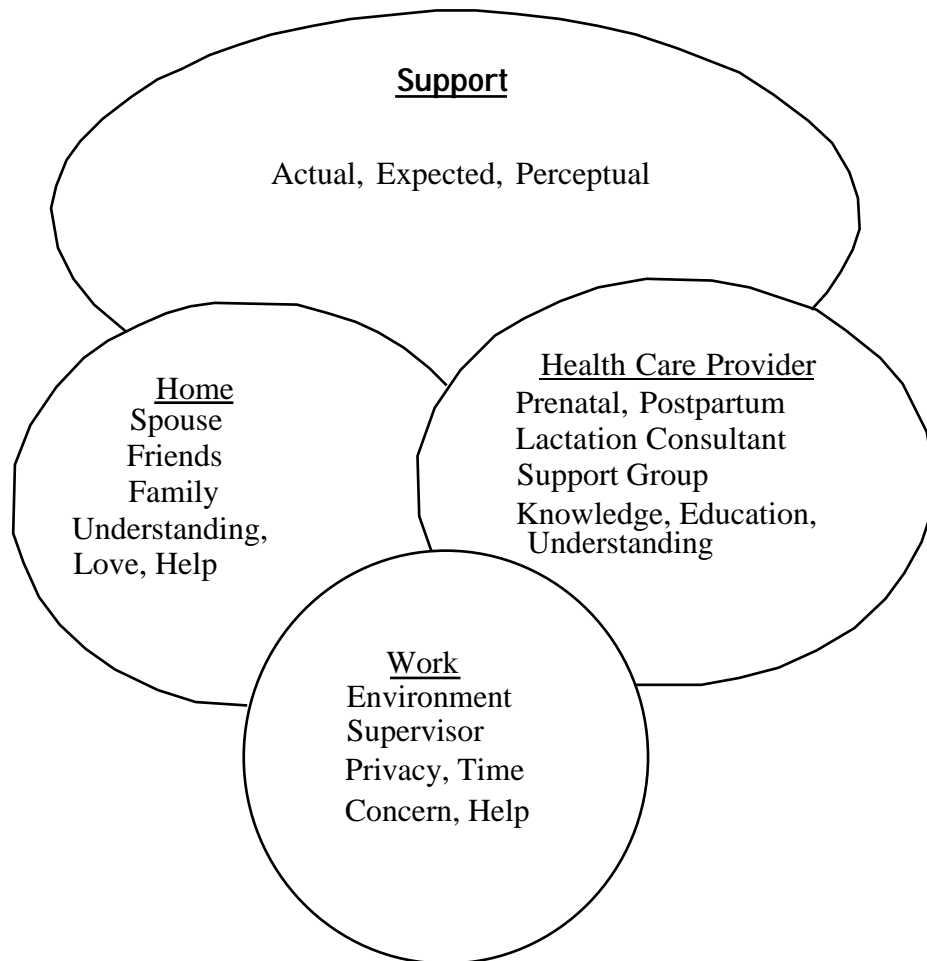


Figure 1

Diagram of Support Needed for Breastfeeding

The participants had a variety of prenatal expectations of breastfeeding, and of themselves regarding breastfeeding. Some, the health care providers, had knowledge about breastfeeding prior to giving birth. They tended to have higher expectations of themselves, blamed themselves for difficulty breastfeeding, and seemed to enter a

downward spiral in discontinuing breastfeeding. They thought they should know how to breastfeed and be able to transfer knowledge into practice. The prenatal concept of breastfeeding being natural, simple, and easy was a stark contrast to the reality that confronted them at the first few postpartum feedings. Films and other literature that are available in prenatal breastfeeding classes show the positive attribute of breastfeeding and tend to minimize the difficulties involved with breastfeeding, such as damp shirts due to leaking breastmilk. Due to the fact that most breastfeeding decisions are made prenatally, women who may potentially breastfeed are susceptible to supportive or disparaging comments and attitudes made by friends, family, and especially health care providers even before the baby is born (Corbett-Dick & Bezek, 1997). The participants found conflicts between the prenatal fantasy of breastfeeding and reality. One of the realities, using the breastpump, was not something that they found enjoyable, but was necessary.

The three health care providers were also the participants who reported the least amount of postpartum breastfeeding education and support from the hospital staff. It is interesting that three of the participants were health care providers, and all reported a lack of support from health care providers when still on the postpartum unit, during routine well baby exams, and with health care providers they encountered at work. This finding led the researcher to wonder why they did not receive the support they needed. Did the postpartum staff assume that because the women are health care providers they already had the knowledge about breastfeeding? Are the staff members unsure of their own breastfeeding knowledge? Was this the way they educate all their patients? There are so many differing viewpoints about breastfeeding that it is understandable that

women feel insecure. They made reference to the “breastfeeding nazi’s” who were not supportive of anything but staying home to feed their infant, as well as health care providers who gave them the green flag to give up breastfeeding. One participant contrasted breastfeeding education and support with childbirth education and support, noting that health care has come a long way in managing childbirth comfortably, that a woman should do what is comfortable for her, but a similar option is not available for breastfeeding. Some of the participants felt they could not breastfeed completely, so gave up. Perhaps the most disappointing finding was that all the health care provider participants mentioned they did not get sufficient support in the workplace from other health care providers. As health care providers we are obliged to promote breastfeeding for our patients. This is a glaring example of not practicing what we preach to others. This finding has been reflected in the medical literature (Miller, Miller, & Chism, 1996). Medical residents were finding a lack of emotional support in the workplace from other physicians and supervisors as well as physical environment that caused them to discontinue or not start breastfeeding.

Another finding that caused much concern were the oft-repeated statements about societal mores. All participants remarked that they felt uncomfortable breastfeeding in public, even discretely, and at home in the presence of other children. The expectation was for them to go to a private place, away from other people, to breastfeed their infant. Expressing breastmilk by using a breastpump was expected to be done privately for fear of exposing a part of the body. More than one health care provider participant reported a perception of resentment in coworkers, that by taking a break to express breastmilk she would be getting an extra privilege or favor that they was not available to them, enabling

participants to get out of work. One participant mentioned that she perceived jealousy from coworkers that had opted not to breastfeed or stopped breastfeeding early. Two health care provider participants reported the perception that taking a smoke break was acceptable, but taking a pump break was less than acceptable, something they had to justify. It is amazing that health care providers promote the unhealthy behavior of smoking, but actually put up roadblocks for healthy behaviors such as breastfeeding. It is also interesting that smoking must be performed, according to federal regulation, at least 50 feet away from a federal building. Whereas a woman expressing breastmilk with a pump usually does not leave the workplace, making the woman accessible for answering questions about a patient or able to quickly respond to an emergency situation and resume pumping when safely able to do so.

All the participants related that well-meaning relatives, friends, coworkers, and health care providers had made statements that actually had underlying negative tones. Some comments were subtle, some overt. “You’ve done it for six months. It’s killin’ ya. Just quit.” Other findings common to the health care provider participants were feelings of inadequacy and high expectations of themselves. Did they have more feelings of inadequacy and higher expectations of themselves than the non-health care provider participant because they were medical personnel, or was it the negative pressure coming from coworkers, other health care providers, family, and friends? Or was it that they had difficulty translating their breastfeeding knowledge into practice? “I think to myself, okay, I’m an educated woman, with one healthy baby, and you get someone out there who doesn’t know what they’re doing and they have triplets. And they’re breastfeeding

and how do they do it”, one study participant stated. All these feelings combined facilitate a downward spiral toward quitting breastfeeding.

This study focused on the barriers of breastfeeding but concurrently identified potential area of intervention that could then become facilitators of breastfeeding. A few modifiable variables have been associated with breastfeeding success, intending to breastfeed for a long time, having an early first feeding, a strong sense of commitment to breastfeeding, having a good support system, avoidance of supplemental nutrition or water, and expressing a positive attitude toward breastfeeding. These influencers can be modified by changes in hospital practice, by a supportive workplace with adequate physical facilities including equipment, by time being allotted for expressing breastmilk, and coverage of work duties, through overt support by administration and supervisor, with specific discussion of this support with the staff, support from family members, coworkers, and from health care providers, including lactation consultants (Lawrence, 1982; Janke, 1993; American Academy of Family Physicians, 1994; Miller et al., 1996; Wright et al., 1996). This study is really the beginning point for looking at breastfeeding experiences of active duty military mothers. Many new questions have risen from this study.

Limitations of the Study

Due to the nature of the phenomenological method the study focused getting rich in-depth interviews from a small, homogenous group of officers from three of the four military services. The study is therefore generalizeable to officer mothers, but does not address possibly different experiences in women of other ranks and socioeconomic groups. One can only speculate that because of somewhat different socioeconomic

levels, stressors, and duty obligations that feeding choices might also be different. There is potential to expand on this study and get more data with follow-up interviews, or a focus group. Some areas could have been probed further, and saturation of all the data, not just a portion of it, would have occurred. Areas that need to be explored further are: spousal relationship changes, changes in roles, habits, lifestyles, balancing of often conflicting roles, the concept of needing to prove self-worth, earn a break, earn right to eat, or take a pumping break, self-neglect, growth as a woman, sacrifice, and trying to do it all without asking for help.

Recommendations for Further Research

Future research might find that individual, private interviews, followed by either another interview or a focus group, would be helpful for ensuring saturation of the data and trustworthiness. Future research might use a methodology such as grounded theory to get a more heterogeneous sample to get the breadth of experience from all military women. Active duty mothers may have differing barriers and facilitators at various times in the postpartum course. Interviewing women two weeks postpartum, at two months postpartum, at six months, and at one year might show changes in barriers and facilitators that are significant clinically. Every woman in this study mentioned lack of practical postpartum support for breastfeeding. The women relied on private lactation consultants, reading of books, and friends for much of their postpartum breastfeeding education. Further research should be done with regard to how breastfeeding is taught postpartum. More research could be done on the sense of martyrdom these women expressed because they did not want to take a break for any reason, etc. A final recommendation for further study is the transition to being a parent and loss of control of one's life, as they knew it

before children as expressed during one of the interviews. This is a fruitful area for future research.

Conclusions

In conclusion, this study of the barriers and facilitators of breastfeeding for primiparous active duty military mothers has been productive in describing the factors that influence how they decide to feed their infant. Additionally, this study extended the scant amount of research that has been conducted for this population. Learning the motivators that influence active duty military women to breastfeed or not to breastfeed may lead to interventions that may potentially increase the initiation and duration of breastfeeding in primiparous active duty military mothers. This qualitative descriptive study using a phenomenological approach has been an effective means of exploring the factors that influence and motivate primiparous active duty military mothers in how they feed their infant.

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Appendix A



Active Duty First-time Mothers of Children aged 6 - 18 months

I am a USUHS graduate student interested in talking to active duty military mothers of an infant aged 6 - 18 months of age about how **YOU** chose to feed your infant, and the things that influenced your choice.



Interested in taking part in my study and talking with me about **YOUR** experience?
CALL Captain K. Bristow at (301) 587-2437

We can meet at your convenience.
I can bring someone to care for your child while we talk for 1-2 hours, if needed.



Appendix B

(Rev 6/98)

Pg 1 of 4

NATIONAL NAVAL MEDICAL CENTER
BETHESDA, MARYLAND

Consent for Voluntary Participation in a Clinical Investigation Study

1. I, _____, have been asked to voluntarily participate in a research project entitled, “Barriers and Facilitators of Breastfeeding for Primiparous Active Duty Military Mothers: a Qualitative Study” being conducted at the National Naval Medical Center, Bethesda, Maryland.
2. The purpose of this research project is to: identify and describe the factors that influence a primiparous (first time mother) active duty military women to breastfeed her infant. This study may be of further benefit in identifying areas of concern and support for active duty military mothers.
3. My participation in this research project will be for a period of 1-2 hours. A brief (approximately one hour) follow-up interview may be necessary to confirm my responses.
4. The procedure for this project involves: I will be interviewed by the researcher and will be asked to describe how I chose to feed my infant and what meaning the choice has for me. I understand that this interview will be a face-to face interview and that it will be audiotaped. The interview will last approximately 1-2 hours. A brief follow-up interview may be necessary to confirm my responses. The questions will focus on my experiences choosing how to feed my infant, the things that influenced my decision, my thoughts and feelings about my experiences, and any recommendations I would make regarding how active duty first-time mothers decide to feed their infants.
5. Specifically, I am aware that the experimental part of this research project is the comparison of the answers that are given to the questions posed in the interview with answers given by other participants in an effort to identify trends or common reasons why active duty mothers choose to breastfeed or not to breastfeed.
6. A total of four subjects are expected to participate in this project.
7. The risks or discomforts which are possible are as follows: I understand that there are no physical risks from participating in the study, however, I may experience some emotional discomfort associated with responding to the questions depending on my experiences in deciding how to feed my infant. If I want to discuss these feelings, I may call CPT Bristow at 301-587-2437, my primary health clinic, or the military mental health clinic at my current location. I accept these risks.

Subject Initials

8. The research may or may not help me personally but the results may help the investigator have a better understanding of the factors that influence active duty military mothers in deciding how to feed their infants. This may in turn improve infant feeding options and support for active duty military mothers.

9. This project is not designed to treat any medical condition that I may have; therefore there is no alternative procedure course of treatment that would be advantageous to me.

10. In all publications and presentations resulting from this research project, my anonymity will be protected to the maximum extent possible; although, I realize that authorized Navy Medical Department personnel may have access to my research file in order to verify that my rights have been safeguarded.

11. If I suffer any physical injury as a result of my participation in this study, immediate medical treatment is available at the National Naval Medical Center, Bethesda, Maryland. Although no compensation is available, any injury as a result of my participation will be evaluated and treated in keeping with the benefits or care to which I am entitled under applicable regulations.

12. If I have any questions regarding this research project, I may contact CPT K. Bristow, AN, at (301) 587-2437 or CDR M. Holder, NC, USN (study sponsor) at (301) 295-5729. If I have any questions regarding my rights as an individual while participating in a research project at the National Naval Medical Center, Bethesda, I can contact one of the Research Administrators, Clinical Investigation Department, at (301) 295-2275. They will answer my questions or refer me to a member of the Institutional Review Board (IRB) for further information. If I believe, I have been injured as a result of this project I may call the legal office (301) 295-2215.

13. My participation in this project is voluntary and that my refusal to participate will involve no penalty or loss of benefits to which I am entitled under applicable regulations. If I choose to participate, I am free to ask questions or to withdraw from the project at any time. If I should decide to withdraw from the research project, I will notify CPT K Bristow, AN at (301) 587-2437, to ensure an orderly termination process. My withdrawal will involve no loss of benefits to which I am entitled.

14. If, in the future, I am no longer eligible for health care as a DOD beneficiary, my participation in this research project does not guarantee me future medical care. If I am no longer a DOD beneficiary, I may not be able to obtain medical treatment from a DOD health care facility for any injuries or side effects that result from my participation in this research project. I may be responsible for seeking treatment elsewhere.

Subject Initials

15. The investigators may terminate my participation in this project for the following reasons: Failure to show for the interview, my refusal to answer questions, my refusal to take part in this project, my withdrawal from the study, natural disaster, war.

16. I understand that I may withdraw from this study at any time without prejudice to my future care and I will not lose any benefits to which I am otherwise entitled.

17. I have been informed that there will not be additional costs to me if I choose to participate in this project.

I certify that I have received a copy of this consent form.

Subject Initials

Date Signed

Subject Signature

Printed Name-Status-SSN

Witness' Signature & Date

Investigator Signature & Date

Witness' typed Name-Rank-SSN

Kristine Bristow, CPT, xxx-xx-xxxx
Investigator typed Name-Rank-SSN

PRIVACY ACT STATEMENT

1. Authority. 5 USC 301
2. Purpose. Medical research information will be collected to enhance basic medical knowledge, or to develop tests, procedures, and equipment to improve the diagnosis, treatment, or prevention of illness, injury or performance impairment.
3. Use. Medical research information will be used for statistical analysis and reports by the Departments of the Navy and Defense, and other U.S. Government agencies, provided this use is compatible with the purpose for which the information was collected. Use of the information may be granted to non-Government agencies or individuals by the Chief, Bureau of Medicine and Surgery in accordance with the provisions of the Freedom of Information Act.
4. Disclosure. I understand that all information contained in this Consent Statement or derived from the experiment described herein will be retained permanently at National Naval Medical Center, Bethesda, Maryland and salient portions thereof may be entered into my health record, I voluntarily agree to its disclosure to agencies or individuals identified in the preceding paragraph and I have been informed that failure to agree to such disclosure may negate the purposes for which the experiment was conducted.

Subject Signature

Signature of Witness

Typed Name, Grade or Rank

Date of birth

Appendix C

INTERVIEW GUIDE

How did you choose to feed your infant?

Possible probes: Could you describe for me what it was like being an active duty mother making choices about how to feed your infant?
When did you decide how you would feed your infant?

What lead you to breastfeed?

Possible probes: How did you decide to breastfeed?
Why did you choose to breastfeed?
Who was helpful in your decision to breastfeed?
What support did you find for your decision to breastfeed?

What were your feeding goals?

Possible probes: Did you meet them?
What did not reaching your goal mean to you?
What did not reaching your goal mean to your relationship with your baby?

What helped you to continue breastfeeding?

Possible probes: What supported your breastfeeding?
Who helped you to continue breastfeeding?

What made it difficult for you to breastfeed? To continue to breastfeed?

Possible probes: How did friends, family, co-workers, boss, care providers make it difficult?

What happened when you went back to work?

How long were you able to breastfeed?

What issues influenced your decision?

If you had to change your plan, what did that mean to you?

How did you make the decision to stop?

What are the positive or negative impacts of stopping breastfeeding?

What are the positive or negative impacts of continuing to breastfeed?

If you were to give other active duty mothers suggestions regarding breastfeeding, what would you tell them?



DEPARTMENT OF THE NAVY

NATIONAL NAVAL MEDICAL CENTER
BETHESDA, MARYLAND 20889-5600

IN REPLY REFER TO

6500
10C/107
4 Jan 99

From: Commander, National Naval Medical Center
To: CDR B. Holder, NC, USN, Nursing Services Directorate
CAPT K. Bristow, AN, USN

Subj: APPROVAL OF CIP RESEARCH PROJECT #B99LH000000-008, "BARRIERS AND FACILITATORS OF BREASTFEEDING FOR PRIMIPAROUS ACTIVE DUTY MILITARY MOTHERS: A QUALITATIVE STUDY"

Ref: (a) NSHSBETHINST 6000.4A
(b) NNMCIINST 6500.2C

Encl: (1) Multiple Project Assurance
(2) Guidelines to Executing a Research Proposal
(3) Consent Form

1. Congratulations! You have been granted approval to conduct your research project at the National Naval Medical Center (NNMC).

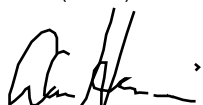
2. Your official research project number is B99-008. Use this number on any correspondence about your research project. This will expedite the processing of your requests. Your research project has a completion target date of June 1999 and you are authorized an enrollment of 4 subjects.

3. Your research project was reviewed per references (a) and (b) was endorsed by our Chairperson, Institutional Review Board (IRB) under our DOD Assurance 40001 and Multiple Project Assurance M-1515. This review was noted in the 10 December 1998 IRB meeting. Enclosure (1) is the MPA that investigators agree to adhere to in conducting research at the National Naval Medical Center.

4. Enclosure (2) is the stamped, approved consent form that must be duplicated and used to enroll new subjects.

5. Support for this research project from any non-appropriated funding source is not authorized, however, collaboration with the Uniformed Services University of the Health Sciences is authorized.

6. Good luck on your research! Be sure to note your research project's requirements of reference (b) which are outlined in enclosure (3). This guidebook provides vital information on such items as your responsibilities as a principal investigator, the required research documentation, the procedure to use when making any changes to your research project, required reports and guidelines for publication and travel. Please do not hesitate to contact the Clinical Investigation Department staff at (301)295-2275 for any further questions or assistance.


ALAN H. HARRIS
By/direction



UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4799



January 8, 1999

MEMORANDUM FOR CAPT KRISTINE M. BRISTOW, GRADUATE SCHOOL OF NURSING

SUBJECT: IRB Review and Approval of Protocol **T06187** for Human Subject Use

Your research protocol, entitled "*Barriers and Facilitators of Breastfeeding for Primiparous Active-Duty Military Mothers: A Qualitative Study*," was reviewed and approved for execution on 1/9/99 as an exempt human subject use study under the provisions of 32 CFR 219.101 (b)(2). This approval will be reported to the full IRB, which is scheduled to meet on February 11, 1999.

The IRB understands that PI will use open-ended interviews to establish a profile of breastfeeding experiences of active-duty, first-time mothers, emphasizing perceived barriers and facilitating factors. The PI will conduct 1-2 hour interviews of 4 subjects recruited from NNMC. Data will be kept in a secure location. Tapes of the interviews will be destroyed when the study is complete, and there will be no other identifying connections between data and subject. Approval for study and recruitment flier has been obtained from NNMC.

Please notify this office of any amendments or changes in the approved protocol that you might wish to make and of any untoward incidents that occur in the conduct of this project. If you have any questions regarding human volunteers, please call me at 301-295-3303.

Richard R. Levine, Ph.D.
LTC, MS, USA
Director, Research Programs and
Executive Secretary, IRB

cc: Director, Grants Administration